Criteria For Non-formulary Use of Aripiprazole (Abilify™)
VHA Pharmacy Benefits Management Strategic Healthcare Group and
the Medical Advisory Panel

These criteria are based on the best clinical evidence currently available. The recommendations in this document are dynamic, and will be revised as new clinical information becomes available. These guidelines are intended to assist practitioners in providing consistent, high quality, cost effective drug therapy. They are not intended to interfere with clinical judgment; the clinician must ultimately decide the course of therapy based on individual patient situations.

First episode or chronic psychosis in relapse

There is no consensus in the literature to support one atypical antipsychotic being globally superior to another; therefore, once the physician determines there are no patient specific issues, begin therapy with an effective, less expensive agent. At the present time, this would lead to the preference of quetiapine and risperidone over olanzapine, ziprasidone, and aripiprazole.

Patients unresponsive or inadequately responding

With the exception of clozapine, there are very few trials on switching from one atypical second-generation antipsychotic to another in treatment unresponsive patients. There are currently no data to suggest that one non-clozapine atypical antipsychotic has superior efficacy over another. Studies with aripiprazole were not designed to evaluate its use in patients who have not responded to other atypical antipsychotic agents. In the absence of patient specific issues and differential efficacy data, consider switching to an effective, less expensive agent such as risperidone or quetiapine.

If the patient has not responded to 2 atypical antipsychotic agents, treatment with clozapine may be considered. Ziprasidone, olanzapine, or aripiprazole are options for those in whom clozapine is not a consideration. Selection should take into account patient characteristics, drug contraindications, adverse events, clinician experience, and cost.

Weight gain

At this time, ziprasidone and aripiprazole are associated with the least amount of weight gain. Clinicians can consider a trial of these agents for patients who have had problematic weight gain (e.g. $\geq$ 7% increase or BMI > 25) while taking another atypical antipsychotic.

Diabetes

The FDA has requested that labeling for ALL atypical antipsychotics carry a warning on the potential risk of developing diabetes. At this time, it is unknown if risk of diabetes differs among the agents.

Dosing

Both the initial and target dose of aripiprazole is 10-15mg once daily. The dose may be increased to a maximum of 30mg daily. The dose may be taken without regard to meals. Dosage adjustment is not needed for patients with renal insufficiency, hepatic insufficiency, or the elderly.

Aripiprazole is metabolized by the CYP2D6 and CYP3A4 isoenzymes. The manufacturer recommends that the dose of aripiprazole be reduced to one-half when co-administered with a strong CYP3A4 or 2D6 inhibitor or be doubled if administered with a strong 3A4 inducer. For a good resource on CYP450 substrates, inducers, and inhibitors refer to http://medicine.iupui.edu/flockhart/

Cost

The current price of aripiprazole is $6.29 for the 10 and 15mg tablets and $8.90 for the 20 and 30mg tablets. It is unknown at this time what the average daily dose and monthly cost for aripiprazole will be within the VA. However, if one were to use the 15mg daily dose as an example, the monthly cost would be $188.70.

Average Dose and Cost in VA Patients with Schizophrenia

	Quetiapine	Risperidone	Ziprasidone	Olanzapine
Average daily dose	269.8mg	3.6mg	95mg	13mg
Average monthly cost	$103.41	$125.67	$140.50	$232.50

For updated cost information and a review of aripiprazole please visit the PBM web site at http://vaww.pbm.med.va.gov or www.vapbm.org